APPLICATION FOR INTENSIVE CARE
NEWBORN NURSERY SERVICE

1. Name and board eligibility or certification status and additional neonatology training or experience of the physician responsible for the service:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

2. Name and board eligibility or certification status of anesthesiologist(s) available to the service:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

3. Name and qualifications of the surgeon(s) performing neonatal surgery: ________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

4. Name and qualifications of pediatric cardiologist(s) available to the service: ________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

5. Name, training and newborn intensive care experience of the nurse responsible for the nursing care:
_______________________________________________________________________________________
_______________________________________________________________________________________

6. Is a registered nurse with training and experience on duty each shift? ☐ YES ☐ NO

7. Is a registered nurse trained in infant resuscitation on duty each shift? ☐ YES ☐ NO

8. Registered nurse to infant ratio/ shift: ____________AM ____________PM ____________NIGHT
9. Does the service have a designated transportation team?  YES  NO

10. Name of the physician on the transportation team: ____________________________________________

11. Name and qualifications of the registered nurse assigned to the transportation team:
____________________________________
____________________________________
____________________________________

12. Name of the respiratory therapist(s) on the transportation team, if provided: ________________
____________________________________

13. List the referring perinatal units by hospital and address: ________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________


15. Does the service provide continuing education for staff of referring perinatal units?  YES  NO